STATE OF TENNESSEE

DEPARTMENT OF COMMERCE AND INSURANCE

TENNCARE DIVISION

and

THE OFFICE OF THE COMPTROLLER OF THE TREASURY

DIVISION OF STATE AUDIT

MARKET CONDUCT EXAMINATION

and

LIMITED SCOPE FINANCIAL AND COMPLIANCE EXAMINATION

OF

BETTER HEALTH PLAN, INC.

MEMPHIS, TENNESSEE

FOR THE PERIOD JANUARY 1, 2003
THROUGH DECEMBER 31, 2003

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DATE: September 28, 2004

The examination fieldwork for a Limited Scope Financial and Compliance Examination and Claims Processing Market Conduct Examination of Better Health Plan, Inc., Memphis, Tennessee, was completed May 5, 2004. The report of this examination is herein respectfully submitted.

I. FOREWORD

This report reflects the results of a market conduct examination "by test" of the claims processing system of Better Health Plan, Inc. ("BHP"). Further, this report reflects the results of a limited scope examination of the financial statement account balances as reported by BHP. This report also reflects the results of a compliance examination of BHP's policies and procedures regarding statutory and contractual requirements. A description of the specific tests applied is set forth in the body of this report and the results of those tests are included herein.

II. PURPOSE AND SCOPE

A. Authority

This examination of BHP was conducted jointly by the TennCare Division of the Tennessee Department of Commerce and Insurance (TDCI) and the Office of the Comptroller of the Treasury, Division of State Audit (Comptroller) under the authority of section 3-6. of the Contractor Risk Agreement between the State of Tennessee and BHP, Executive Order No. 1 dated January 26, 1995, and § 56-32-215 of the Tennessee Code Annotated (Tenn. Code Ann.).

BHP is licensed as a health maintenance organization (HMO) in the state and participates by contract with the state as a managed care organization (MCO) in the TennCare Program. The TennCare Program is administered by the TennCare Bureau within the Tennessee Department of Finance and Administration.

B. Areas Examined and Period Covered

The market conduct examination focused on the claims processing functions and performance of BHP. The testing included an examination of internal controls surrounding claims adjudication, claims processing system data integrity, notification of claims disposition to providers and enrollees, and payments to providers.

The limited scope financial examination focused on selected balance sheet accounts and the TennCare income statements as reported by BHP on its National Association of Insurance Commissioners (NAIC) annual statement for the year ended December 31, 2003, and the Medical Fund Target Report filed by BHP as of December 31, 2003.

The limited scope compliance examination focused on BHP's provider appeals procedures, provider agreements and subcontracts; the demonstration of compliance

with Federal Title VI of the 1964 Civil Rights Act and the Insurance Holding Company Act.

Fieldwork was performed using records provided by BHP before and during the onsite examination, at the Memphis, Tennessee office from April 19 through April 25, 2004, and the Monroeville, Pennsylvania office from May 3 through May 5, 2004.

C. Purpose and Objective

The purpose of the examination was to obtain reasonable assurance that BHP's TennCare operations were administered in accordance with the Contractor Risk Agreement, and state statutes and regulations concerning HMO operations, thus reasonably assuring that the BHP TennCare members received uninterrupted delivery of health care services on an ongoing basis.

The objectives of the examination were to:

- Determine whether BHP met certain contractual obligations under the Contractor Risk Agreement and whether BHP was in compliance with the regulatory requirements for HMOs set forth in Tenn. Code Ann. § 56-32-201 *et seq.*;

- Determine whether BHP had sufficient financial capital and surplus to ensure the uninterrupted delivery of health care services for its members on an ongoing basis;

- Determine whether BHP properly adjudicated claims from service providers and made payments to providers in a timely manner; and

- Determine whether BHP had implemented an appeal system to reasonably resolve appeals from TennCare providers in a timely manner.

III. PROFILE

A. Administrative Organization

BHP was chartered in the State of Tennessee on August 9, 2000, for the purpose of providing managed health care services to individuals participating in the State's TennCare Program. BHP is a wholly owned subsidiary of Three Rivers Holdings, Inc. (TRH).

The officers and board of directors for BHP at December 31, 2003, were as follows:

Officers for BHP

Warren Carmichael, President and CEO
Jennifer Kessler, Vice President Marketing and Provider Relations
Fred Madill, Vice President Operations
David Thomas, Vice President and General Counsel
Leslie Gelpi, Vice President Finance/Assistant Treasurer/Assistant Secretary
Shirley Blevins, Vice President Medical Operations
William Lawson Jr., Secretary/Treasurer
Heather Miller, Compliance Officer

Board of Directors for BHP

Warren Carmichael John H. Dobbs, Jr. William Lawson, Jr.

B. Brief Overview

On July 1, 2001, TDCI issued BHP a certificate of authority to operate as an HMO. At the same time BHP entered into a Contractor Risk Agreement with the TennCare Bureau.

Effective July 1, 2002, the Contractor Risk Agreement with BHP was amended to temporarily operate under a non-risk agreement. This period, otherwise known as the "stabilization period," was established to allow all MCOs a satisfactory period of time to establish financial stability, maintain continuity of a managed care environment for enrollees and assist the Bureau of TennCare in restructuring the program design to better serve Tennesseans adequately and responsibly. BHP agreed not to make any change to the reimbursement rates, reimbursement policies and procedures, and medical management policies in effect on April 16, 2002, unless such changes received approval in advance by the Bureau of TennCare.

During the stabilization period, BHP receives from the TennCare Bureau a monthly fixed administrative payment based upon the number of TennCare enrollees assigned to BHP. The TennCare Bureau reimburses BHP for the cost of providing covered services to TennCare enrollees.

During the period under examination, BHP was licensed by TDCI and the TennCare Bureau to participate in the TennCare program in the West Tennessee Grand Region.

All premium revenue earned by BHP is from payments received for enrollees assigned by the TennCare Bureau. As of December 31, 2003, BHP had approximately 45,100 TennCare members.

C. Claims Processing Not Performed by BHP

During the period under examination, BHP subcontracted with the following vendor for the provision of specific TennCare benefits and the processing and payment of related claims submitted by providers:

- Advance PCS Health, LP, for pharmacy.
- Three Rivers Administrative Services, for medical.

Except for timeliness testing of pharmacy claims, pharmacy claims were not otherwise tested as part of the examination. As of July 1, 2003, BHP was no longer contractually responsible for pharmacy benefits. The TennCare Bureau contracted directly with a single pharmacy benefits manager as of July 1, 2003, for the provision of pharmacy benefits to all TennCare enrollees.

IV. PREVIOUS EXAMINATION FINDINGS

This is the initial examination of BHP by both TDCI and the Comptroller.

V. SUMMARY OF CURRENT FINDINGS

The summaries of current factual findings are set forth below. The details of testing as well as managements comment to each finding can be found in Sections VI, VII and VIII of this examination report.

A. Financial Analysis

1. BHP should improve the methodology utilized for the allocation of management fees to NAIC expense categories by initially identifying salaries and compensation incurred by the management company which are 100% related to BHP or other affiliates. Salaries and compensation that are related 100% to a plan should be allocated to the specific plan before other pertinent ratios are applied. Any change to the methodology will not effect reported net income or net worth but the improved methodology will provide a more accurate representation of administrative expense on NAIC financial statements. (See Section VI.A.3.)

2. The following deficiencies were noted in BHP's Supplemental TennCare Operations Statement (Report 2A) for the period ended December 31, 2003.

   - No amounts were reported in the line items for "Copayments" and "Subrogation and Coordination of Benefits." The recovery amounts related to these line items were incorrectly netted against other medical expense categories.

   - Premium tax reimbursements have not been included as a component of premium revenue. Additionally, premium tax payments related to the non-risk period have not been reported as premium tax expense.

   The deficiencies of Report 2A will not effect BHP's reported net income or net worth as of December 31, 2003, however, Report 2A should present BHP's operations as if BHP were still operating at risk. (Section VI.B.)

B. Claims Processing System

There were no deficiencies discovered during the market conduct examination of BHP's claims processing system for the period January 1, 2003, through December 31, 2003.

C. Compliance Testing

1. The following deficiencies were noted during review of provider complaints:

   - As of examination fieldwork, BHP did not have written policies and procedures to process provider complaints.

   - The provider complaint log lacks the following elements: nature of the claim dispute, claim resolution, and indication of provider notification.

   After examination fieldwork was completed, BHP developed written policies and procedures for the processing of provider complaints. The missing elements to the provider complaint log have been added. (See Section VIII.A.)

2. As of examination fieldwork, BHP had not submitted its provider manual to TDCI for review and approval. BHP's provider agreements reference BHP's provider manual for written guidelines as it pertains to standards for care, utilization review/quality improvement, claims processing and other procedural requirements. These references incorporate the provider manual into the

provider agreements, and therefore the provider manual requires prior approval in accordance with Tenn. Code Ann. § 56-32-203(c)(1). (See Section VIII.B.)

3. During testing of financial requirements of the Contractor Risk Agreement, it was discovered that two provider agreements were amended, yet the amendments were not submitted for prior approval to TDCI before implementation. One of the provider agreements had been amended four times, without prior approval as required by Tenn. Code Ann. § 56-32-203(c)(1). (See Section VIII.C.)

VI. DETAIL OF TESTS CONDUCTED – FINANCIAL ANALYSIS

A. Financial Analysis

As an HMO licensed in the State of Tennessee, BHP is required to file annual and quarterly financial statements in accordance with NAIC and statutory guidelines with the Tennessee Department of Commerce and Insurance. The department uses the information filed in these reports to determine if BHP meets the minimum requirement for statutory reserves. The statements are filed on a statutory basis of accounting. Statutory accounting differs from generally accepted accounting principles because "admitted" assets must be easily convertible to cash, if necessary, to pay outstanding claims. "Non-admitted" assets such as furniture, equipment, and prepaid expenses are not included in the determination of plan assets and should not be considered when calculating capital and surplus.

At December 31, 2003, BHP reported $9,648,917 in admitted assets, $5,644,209 in liabilities and $4,004,708 in capital and surplus on its NAIC annual statement. BHP reported total net income of $270,606 on its statement of revenue and expenses.

1. Capital and Surplus

Tenn. Code Ann. § 56-32-212(a)(2) requires BHP to establish and maintain a minimum net worth equal to the greater of (1) $1,500,000 or (2) an amount totaling 4% of the first $150 million of annual premium revenue earned for the prior calendar year, plus 1.5% of the amount earned in excess of $150 million for the prior calendar year.

Tenn. Code Ann. § 56-32-212(a)(2) includes in the definition of premium revenue "any and all payments made by the state to any entity providing health care services pursuant to any federal waiver received by the state that waives any or all of the provisions pursuant to any other federal law adopted by amendment to the required Title XIX state plan." Based on this definition, all TennCare

payments made to an HMO licensed in Tennessee are included in the calculation of net worth and deposit requirements.

2003 Net Statutory Net Worth Calculation

BHP's premium revenue per documentation obtained from the TennCare Bureau totaled $65,913,205 for the calendar year 2003; therefore, based upon Tenn. Code Ann. § 56-32-212(a)(2), BHP's current minimum statutory net worth requirement is $2,636,528. Before the July 2001 implementation, BHP was required to demonstrate as part of the "Request for Response" process an enhanced minimum net worth of $2,956,800. Until such time as the statutory net worth requirement exceeds the enhanced net worth requirement, the enhanced net worth requirement will be utilized. BHP reported total capital and surplus of $4,004,708 as of December 31, 2003, which is $1,047,908 in excess of the minimum enhanced net worth requirement.

Premium Revenue for the Examination Period

For the examination period January 1 through December 31, 2003, the following is a summary of BHP's premium revenue as defined by Tenn. Code Ann. § 56-32-212(a)(2):

Administrative fee payments from the TennCare Bureau for the period January 1 through December 31, 2003	$6,236,014
Reimbursement for covered services from the TennCare Bureau for the period January 1 through December 31, 2003	58,192,377
Reimbursement for premium tax payments from the TennCare Bureau for the period January 1 through December 31, 2003	1,321,724
Prior year capitation payments from the TennCare Bureau received during the period January 1 through December 31, 2003	163,090
Total premium revenue January 1 through December 31, 2003	$65,913,205

2. Restricted Deposit

Tenn. Code Ann. § 56-32-212(b)(2) and § 56-32-212(b)(3) requires all HMOs licensed in the state to maintain a deposit equal to $900,000, plus an additional $100,000 for each $10 million or fraction thereof of annual premium revenue in excess of $20 million and less than $100 million as reported on the most recent

annual financial statement filed with TDCI, plus $50,000 for each $10 million or fraction thereof of annual premium revenue in excess of $100 million. As previously noted, Tenn. Code Ann. § 56-32-212(a)(2) includes in the definition of premium revenue "any and all payments made by the state to any entity providing health care services pursuant to any federal waiver received by the state that waives any or all of the provisions pursuant to any other federal law adopted by amendment to the required Title XIX state plan."

Based upon premium revenues for calendar year 2003 totaling $65,913,205, BHP's statutory deposit requirement at December 31, 2003, is $1,400,000. BHP has on file with TDCI the necessary safekeeping receipts documenting that deposits totaling $1,400,000 have been pledged for the protection of the enrollees in the State of Tennessee.

3. Management Agreement and Administrative Expense Allocations

BHP contracts with Three Rivers Administrative Services, LLC (TRAS) to provide management services. TRAS is a wholly owned subsidiary of Three Rivers Holdings, Inc., the company that also wholly owns BHP. Effective August 2002, the management fee paid to TRAS was 95% of the administrative fees earned by BHP under the TennCare program. The management agreement defines that all expenses to administer the terms of the Contractor Risk Agreement shall be paid by TRAS. The management fee paid by BHP to TRAS is not detrimental to the financial stability of the plan. Changes to the management agreement have been previously approved by TDCI as a material modification to BHP's Certificate of Authority to operate as a HMO.

For NAIC financial statement reporting purposes, the management fee must be apportioned to the administrative expense categories defined on NAIC annual and quarterly financial statements. The NAIC's Statements of Statutory Accounting Principles No. 70 requires that expenses under a management contract shall be apportioned to the entities incurring the expense as if the expense has been paid solely by the incurring entity. TRAS allocates all administrative expense incurred on behalf of affiliates by the number of enrollees for each affiliate.

Salaries and compensation represent the largest percentage of expenses incurred by TRAS on behalf of BHP and affiliates. The salaries and compensation incurred for several cost centers and individuals can be identified as 100% related to a specific plan.

BHP should improve the methodology utilized for the allocation of management fees to NAIC expense categories by initially identifying salaries and compensation incurred by TRAS which are 100% related to BHP or other affiliates. Salaries and compensation that are related 100% to a plan should be allocated to the specific plan before other pertinent ratios are applied. Any change to the methodology will not effect reported net income or net worth but the improved methodology will provide a more accurate representation of administrative expenses on NAIC financial statements.

Management's Comment

BHP concurs and provides the following response to findings specified in VI.A.3 Management Agreement & Administrative Expense Allocations:

TRAS expenses were allocated between the various HMOs that are its clients based on costs identified for each such client. Some examples of costs specially identified for BHP include rent for the Tennessee office, travel expenses, cell phones, recruiting expenses, EDI admin fees, and printing costs. Expenses that are not identified as incurred for a specific client were allocated between and among all TRAS' clients based on membership, e.g. if an HMO enrolled 25% of the membership of all HMOs that are TRAS' clients, 25% of TRAS expenses would be allocated to that HMO. BHP believes this method is reasonable and appropriate given the information currently available.

For future reports, expenses incurred by TRAS will be analyzed to ensure the administrative expense allocation methodology is reasonable. This analysis will include, where possible, identifying additional specific expenses related to BHP. Salaries and compensation of employees who can be identified as working exclusively on BHP business will be allocated to BHP. For departments that do not have employees working exclusively on one company, we will ensure the method of allocating salaries and compensation is reasonable and appropriate.

4. Tax Allocation Agreement

TRH has made an election to be treated as a Subchapter S Corporation for federal and state income tax purposes with BHP as a qualified Subchapter S subsidiary for federal income tax purposes. As a result of the election, BHP is treated as a division of TRH for income tax purposes and the results of BHP's operations are included in TRH's income tax returns.

Pursuant to a tax allocation agreement with TRH, BHP is required to reimburse TRH for income tax liability it or its owners would incur with respect to BHP's operations. The amount reimbursed is calculated to equal the federal income tax BHP would have paid if it were a C corporation filing a separate income tax return.

TDCI approved this agreement January 15, 2004, with the following conditions:

- All distributions are made from unassigned surplus.
- The distributions are not extraordinary as defined by Tenn. Code Ann. § 56-11-206(b)(2).
- TDCI is notified 10 days prior to any distribution as defined by Tenn. Code Ann. § 56-11-205(e).
- Distributions will be disclosed in item 5 of the annual Form B filing as required by Tenn. Code Ann. § 56-11-203(b).

5. Claims Payable

As of December 31, 2003, BHP reported $4,898,815 in claims unpaid on the 2003 NAIC annual statement. This amount represents $18,360 for estimates of unpaid claims or incurred but not reported (IBNR) for the "at risk" period ending June 30, 2002, and $4,880,455 for a contractual requirement that BHP achieve an 85% medical loss ratio through June 30, 2002. BHP was required to submit to TennCare a plan for approval to distribute to providers funds related to the 85% medical loss ratio contractual requirement. Subsequent to the examination period, BHP received approval from the TennCare Bureau to distribute these funds as of March 1, 2004. BHP's claims unpaid as reported on the December 31, 2003, NAIC Annual Financial Statement appears reasonable.

6. Interest Earned on State Funds

Section 3-10.h.2(d) of the Contractor Risk Agreement states interest generated by funds on deposit for provider payments related to the non-risk agreement period shall be the property of the State. As of the examination fieldwork date, BHP had remitted to the State interest earned on deposits for provider payments related to the non-risk agreement period.

7. Recovery Amounts/Third Party Liability

Section 3-10.h.2(f) of the Contractor Risk Agreement states third party liability recoveries and subrogation amounts related to the non-risk agreement period be reduced from medical reimbursement requests to the TennCare Bureau. BHP reduced medical reimbursement requests to the TennCare Bureau for the amounts recovered from third party liabilities and subrogation.

B. Administrative Services Only (ASO)

As previously mentioned, effective July 1, 2002, BHP's Contractor Risk Agreement was amended so that BHP would operate in a non-risk manner or as an ASO until December 31, 2003. The stabilization period has since been extended to December 31, 2004. Under the NAIC guidelines for an ASO, the financial statements for an ASO exclude all income and expenses related to claims, losses, premiums, and other amounts received or paid on behalf of the uninsured ASO. In addition, administrative fees and revenue are deducted from general administrative expenses. Further, ASO lines of business have no liability for future claim payments; thus, no provisions for IBNR are reflected in the balance sheet for claims with dates of service after June 30, 2002.

The Contractor Risk Agreement requires a deviation from ASO guidelines. The required submission of the supplemental TennCare Operating Statement should include quarterly and year-to-date revenues earned and expenses incurred as a result of the contractor's participation in the State of Tennessee's TennCare program as if BHP were still operating at-risk. Section 2-10.i. of the Contractor Risk Agreement requires BHP to provide "an income statement addressing the TennCare operations." BHP provided this information on the Supplemental TennCare Operations Statement (the "Report 2A").

The following deficiencies were noted in BHP's presentation of Report 2A for the period ended December 31, 2003.

- No amounts were reported in the line items for "Copayments" and "Subrogation and Coordination of Benefits." The recoveries were incorrectly netted against other medical expense categories.

- Premium tax reimbursements have not been included as a component of premium revenue. Additionally, premium tax payments related to the non-risk period have not been reported as an expense.

The deficiencies in preparing Report 2A will not effect BHP's reported net income or net worth; 2003, however, Report 2A should present BHP's operations as if BHP were still operating at risk.

Management's Comment

BHP concurs and provides the following comments to address the findings detailed in VI.B – ASO:

Beginning with the first quarter 2004, "Copayments" and "Subrogation and Coordination of Benefits" are reported on the appropriate lines of the TennCare Operations Statement (Report 2A). Also, beginning with the first quarter 2004, premium tax reimbursements have been included as a component of premium revenue and premium tax payments related to the non-risk period have been reported as premium tax expense. BHP believes these actions will remedy any misconceptions, which might have arisen based on the prior reporting practices noted in these findings.

C. Medical Fund Target

Effective July 1, 2002, the Contractor Risk Agreement requires BHP to submit a Medical Fund Target (MFT) report monthly. The MFT accounts for medical payments and IBNR based upon month of service as compared to a target monthly amount for the enrollees' medical expenses. Although estimates for IBNR claims for ASO plans are not included in the NAIC financial statements, these estimates are required to be included in the MFT. BHP submitted monthly MFT reports which reported actual and estimated monthly medical claims expenditures to be reimbursed by the TennCare Bureau. The estimated monthly expenditures are supported by a letter from an actuary which indicates that the MFT estimates for incurred but not reported expenses have been reviewed for accuracy.

No discrepancies were noted during the review of documentation supporting the amounts reported on the Medical Fund Target reports.

D. Schedule of Examination Adjustments to Capital and Surplus

There were no examination adjustments to capital and surplus.

VII. DETAIL OF TESTS CONDUCTED – CLAIMS PROCESSING SYSTEM

A. Time Study of Claims Processing

The purpose of conducting a time study of claims is to determine whether BHP pays claims promptly within the time frames set forth in Tenn. Code Ann. § 56-32-226(b)(1), and section 2-18. of the Contractor Risk Agreement. The statute mandates the following prompt pay requirements:

> The health maintenance organization shall ensure that ninety percent (90%) of claims for payments for services delivered to a TennCare enrollee (for which no further written information or substantiation is required in order to make payment) are paid within thirty (30) calendar days of the receipt of such claims. The health maintenance organization shall process, and if appropriate pay, within sixty (60) calendar days ninety-nine point five percent (99.5%) of all provider claims for services delivered to an enrollee in the TennCare program.
>
> > (A) "Pay" means that the health maintenance organization shall either send the provider cash of cash equivalent in full satisfaction of the allowed portion of the claim, or give the provider a credit against any outstanding balance owed by that provider to the health maintenance organization.
> >
> > (B) "Process" means the health maintenance organization must send the provider a written remittance advice or other appropriate written notice evidencing either that the claim had been paid or informing the provider that a claim has been either partially or totally "Denied" and specify all known reason for denial. If a claim is partially or totally denied on the basis the provider did not submit any required information or documentation with the claim, then the remittance advice or other appropriate written notice must specifically identify all such information and documentation.

TDCI had previously requested data files from all TennCare MCOs containing all claims processed during the months of January 2003, April 2003, July 2003, and October 2003. The dates of services of claims processed during these four months are of the most relevance to the examination period. Separate files were submitted for medical and pharmacy claim types. Pharmacy claims were submitted only for January 2003, and April 2003, since as of July 1, 2003, BHP was no longer contractually responsible for pharmacy benefits. Each set of data was tested in its entirety for

compliance with the prompt pay requirements of Tenn. Code Ann. Because these tests were performed on all claims processed in January 2003, April 2003, July 2003, and October 2003, no projections to the population are needed. Listed below are the results of these analyses:

Medical Results

	Within 30 days	Within 60 days	Compliance
T.C.A. Requirement	90%	99.5%	
January 2003	99.74%	99.90%	**Yes**
April 2003	99.77%	99.97%	**Yes**
July 2003	99.50%	99.86%	**Yes**
October 2003	99.25%	99.97%	**Yes**

Pharmacy Results

	Within 30 days	Within 60 days	Compliance
T.C.A. Requirement	90%	99.5%	
January 2003	100%	100%	**Yes**
April 2003	100%	100%	**Yes**

BHP processed claims timely in accordance with Tenn. Code Ann. § 56-32-226(b)(1) for claims processing requirements in the months of January 2003, April 2003, July 2003, and October 2003.

B. Determination of the Extent of Test Work of the Claims Processing System

Several factors were considered in the determination of the extent of test work to be performed in the testing of BHP's claims processing system.

The following items were reviewed to determine the risk that BHP had not properly processed claims:

- Complaints on file with TDCI related to accurate claims processing
- Results of prompt pay testing by TDCI
- Results reported on the claims payment accuracy report submitted to TDCI and the TennCare Bureau
- Review of the preparation of the claims processing accuracy report
- Review of internal controls

No significant weaknesses were noted in these reviews; thus, risk was determined to be low and substantive tests were not increased.

C. Claims Payment Accuracy Report

Section 2-9. of the Contractor Risk Agreement requires that 97% of claims are paid accurately upon initial submission. BHP is required to submit quarterly a claims payment accuracy report 30 days following the end of each quarter.

BHP reported the following results for the year ended December 31, 2003:

	# of claims tested	**Results Reported**	**Compliance**
First Quarter 2003	401	98.25%	**Yes**
Second Quarter 2003	400	99.25%	**Yes**
Third Quarter 2003	400	99.50%	**Yes**
Fourth Quarter 2003	400	98.75%	**Yes**

1. Procedures to Review the Claims Payment Accuracy Reporting

The review of the claims processing accuracy report included an interview with responsible staff to determine the policies, procedures, and sampling methodologies surrounding the preparation of the claims payment accuracy report. These interviews were followed by a review of the supporting documentation used to prepare the fourth quarter 2003 claims payment accuracy report. This review included verification that the number of claims tested by the MCO constituted an adequate sample to represent the population.

In addition, claims were selected at random by TDCI and the Comptroller from the MCO's fourth quarter 2003 claim payment accuracy report. These claims were reviewed to determine if the information on the supporting documentation was correct. The supporting documents were tested for mathematical accuracy. The amounts from the supporting documentation traced directly to the actual report filed with TennCare.

2. Results of Review of the Claims Payment Accuracy Reporting

The quarterly claims payment accuracy report for the fourth quarter of 2003 was selected for review. Five claims were judgmentally selected for testing by TDCI

and the Comptroller to verify BHP's testing accuracy. Also, all claims identified in the report with errors were reviewed to ensure the errors have been corrected. No deficiencies were noted.

D. Claims Selected For Testing

Sixty claims were selected for testing. BHP provided data files of paid and denied claims for the months of January 2003, April 2003, July 2003, and October 2003. For each claim processed, the data file included the date received, date paid, the amount paid and, if applicable, an explanation for denial of payment. From each data file, 15 claims were randomly selected.

The number of claims selected for testing was not determined statistically. The results of testing are not intended to represent the percentage of compliance or non-compliance within the total population of claims.

To ensure that the January 2003, April 2003, July 2003, and October 2003, data files included all claims processed in the month, the total amount paid per each of the data files was reconciled to the triangle lags and to the general ledger for the respective accounting periods to within an acceptable level.

E. Comparison of Actual Claim with System Claim Data

The purpose of this test is to ensure that the information submitted on the claim was entered correctly in the claims processing system. Attachment XII of the Contractor Risk Agreement lists the minimum required data elements to be captured from medical claims and reported to TennCare as encounter data. Original hard copy claims were requested for the 60 claims tested. If the claim was submitted electronically, the original electronic submission file associated with the claim was requested.

The data elements of Attachment XII recorded on the claims selected were compared to the data elements entered into BHP's claims processing system. No discrepancies were noted.

F. Adjudication Accuracy Testing

The purpose of adjudication accuracy testing is to determine if claims selected were properly paid, denied, or rejected.

For the 60 claims selected for testing, no discrepancies were noted.

G. Price Accuracy Testing

The purpose of price accuracy testing is to determine whether payments for specific procedures are in accordance with the system price rules assigned to providers, whether payments are in accordance with provider contracts, and whether amounts are calculated correctly.

For the 60 claims selected for testing, no discrepancies were noted

H. Copayment Testing

The purpose of testing copayments is to determine if enrollees are subject to out-of-pocket payments for certain procedures, within liability limitations, and if out-of-pocket payments are accurately calculated in accordance with section 2-3.K. of the Contractor Risk Agreement.

For one of the 60 claims, the enrollee associated with the claim had copayment responsibilities. No discrepancies were noted.

I. Remittance Advice Testing

The purpose of remittance advice testing is to determine whether remittance advices sent to the provider accurately reflect the processed claim information in the system.

The remittance advices for 10 of the 60 claims were randomly selected for testing to compare the payment and/or denial reasons per the claims processing system to the information communicated to the providers. No differences were noted between the claims payment per the claims processing system and the information communicated to the providers.

J. Analysis of Cancelled Checks

The purpose of analyzing cancelled checks is to verify the actual payment of claims by BHP, and determine whether a pattern of significant lag times exists between the issue date and the cleared date on the checks examined.

The cancelled checks for the 60 claims tested were requested. The check amounts agreed with the amounts paid per the remittance advices and no pattern of significant lag times between the issue date and the cleared date was noted.

K. Pended Claims

The purpose of testing pended claims is to determine the existence of claims that have been suspended or pended by BHP, the reasons for suspending the claims, the number of suspended claims that are over 60 days old, and whether a potential material unrecorded liability exists. BHP provided the examiners a pended claims report as of May 4, 2004. BHP reported a total of 5,487 pended claims of which none were over 60 days old. The review of the pend file does not indicate a potential material unrecorded liability.

L. Electronic Claims Capability

Section 2-9.g. of the Contractor Risk Agreement states, "The CONTRACTOR shall have in place, an automated claims processing system capable of accepting and processing claims submitted electronically with the exception of claims that require written documentation to justify payment. . . ." Section 2-2.h. of the Contractor Risk Agreement required MCOs to move to electronic billing. The electronic billing of claims allows the MCO to process claims more efficiently and cost effectively.

The Health Insurance Portability and Accountability Act, Title II ("HIPAA") requires that all health plans be able to transmit and accept all electronic transactions in compliance with certain standards as explained in the statute by October 15, 2002. The U.S. Department of Health and Human Services extended the deadline until October 15, 2003, for health plans requesting additional time. Failure to comply with the standards defined for the transactions listed can result in the assessment of substantial penalties.

BHP's has implemented the necessary changes to process claims per the standards outlined in the HIPAA statutes. BHP is currently processing claims under these standards for some providers.

M. Mailroom Testing and Claims Inventory Controls

The purpose for the review of mailroom and claims inventory controls is to determine if procedures followed by BHP ensure that all claims received from providers are either returned to providers where appropriate or processed by the claims processing system. The review of mailroom and claims inventory controls included a walk through with mailroom and claims processing personnel. Based on the review, controls in the mailroom and claims inventory controls were adequate.

Ten claims were judgmentally selected from a batch of incoming mail on May 3, 2004, to determine if the claims were entered into the claims processing system with

correct received date. All ten claims were entered into the claims processing system with correct received date.

VIII. REPORT OF OTHER FINDINGS AND ANALYSES – COMPLIANCE TESTING

A. Provider Complaints

The purpose for testing provider complaints is to determine if BHP has developed adequate procedures to ensure provider complaints are responded to in a timely manner.

Eight complaints were judgmentally selected for testing from the 2003 complaint log maintained by BHP. The provider complaints tested were all responded to within 30 days.

The following deficiencies were noted during review of provider complaints:

- As of examination fieldwork, BHP did not have written policies and procedures to process provider complaints.

- The provider complaint log lacked the following elements: nature of the claim dispute, claim resolution, and indication of provider notification.

After examination fieldwork, BHP developed written policies and procedures for the processing of provider complaints. The missing elements to the provider complaint log have also been added.

Management's Comment

BHP concurs and as noted in the audit findings, BHP already implemented corrective action to create written policies and procedures for provider complaints and to include the required elements in its provider complaint log.

B. Provider Manual

The provider manual outlines written guidelines to providers to assure that claims are processed accurately and timely. In addition, the provider manual informs providers of the correct procedures to follow in the event of a disputed claim.

BHP's provider agreements reference BHP's provider manual for written guidelines as it pertains to standards for care, utilization review/quality improvement, claims processing and other procedural requirements. These references incorporate the provider manual into the provider agreements, and therefore the provider manual requires prior approval in accordance with Tenn. Code Ann. § 56-32-203(c)(1).

As of examination fieldwork, BHP had not submitted its provider manual to TDCI for review and approval.

Management's Comment

BHP's Provider Manual covers multiple subjects, such as plan contact information, telephone and fax numbers, PCP change process information, BHO identification, the Member Handbook, claim form and address requirements, descriptions of various provider services offered by the plan, etc. Many of the items contained in or covered by the Provider Manual describe preferred methods for day-to-day interaction between the Plan and participating providers. In some instances, BHP must be able to make rapid changes to this information in order to ensure the timely dissemination of information to participating providers. In our view, the Provider Manual itself is not a required element to be submitted to TDCI for review as part of the COA review as described in T.C.A. § 56-32-203(b). Rather, if we correctly understand TDCI's concerns, it is the incorporation of the Provider Manual in the provider participation agreements, which are mandatory elements for COA review under T.C.A. § 56-32-203(b)(4) that generates this finding. Accordingly, as we believe the minutia of day to day operational interaction issues detailed in the Provider Services Manual to be a matter that is not statutorily required as part of COA review, BHP proposes to revise its provider agreements so that the Provider Manual is no longer incorporated by reference therein. In that setting, as the Provider Manual will no longer be made part of the provider participation agreements, any changes to the Provider Manual will no longer constitute a material modification of BHP's COA under T.C.A. § 56-32-203(c)(1).

Rebuttal by TDCI

TDCI will review BHP revised provider agreements when submitted to ensure that the Provider Manual is no longer incorporated by reference therein.

C. Provider Agreements

Agreements between an HMO and medical providers represent operational documents to be prior approved by TDCI in order for TDCI to grant a certificate of authority for a company to operate as an HMO as provided by Tenn. Code Ann. § 56-32-203(b)(4). The HMO is required to file a notice and obtain the Commissioner's approval prior to any material modification of the operational documents in accordance with Tenn. Code Ann. § 56-32-203(c)(1). Additionally, the TennCare Bureau has defined through contract with the HMO minimum language requirements to be contained in the agreement between the HMO and medical providers. These minimum contract language requirements, include but are not limited to; standards of care, assurance of TennCare enrollees rights, compliance with all Federal and State laws and regulations, and prompt and accurate payment from the HMO to the medical provider.

Per Section 2-9. of the Contractor Risk Agreement between BHP and the TennCare Bureau, all template provider agreements and revisions thereto must be approved in advance by the TennCare Division, Department of Commerce and Insurance in accordance with statutes regarding the approval of an HMO's certificate of authority and any material modification thereof. Additionally, Section 2-18. of the Contractor Risk Agreement requires that all provider agreements executed by BHP shall at a minimum meet the current requirements listed in Section 2-18. of the Contractor Risk Agreement.

Five provider agreements related to claims selected for testing were reviewed to determine if they contained all the minimum language requirements of Section 2-18. of the Contractor Risk Agreement. All five agreements met the minimum language requirements of Section 2-18. as of April 1, 2004. However as noted in Section VIII.B., the provider agreements reference the provider manual. These references incorporate the provider manual into the provider agreements, and therefore the provide manual requires prior approval in accordance with Tenn. Code Ann. § 56-32-203(c)(1).

Furthermore, during testing of financial requirements of the Contractor Risk Agreement, it was discovered that two provider agreements had been amended, yet the amendments were not submitted for prior approval to TDCI before implementation. One of these provider agreements had been amended four times, without prior approval as required by with Tenn. Code Ann. § 56-32-203(c)(1).

Management's Comment

As to the finding which addresses the Provider Manual, please see the action described above through which that Manual will no longer incorporated by reference in the agreements, thereby removing the need for COA review of the Manual under T.C.A. § 56-32-203. As to the provider participation Agreements which were amended without TDCI approval, BHP notes that in February 2004, it updated all provider agreements to include the items required by Section 2-18 of the CRA. While it is regrettable that these agreements were originally amended without TDCI approval, the amendment issued in early 2004 to update all provider agreements with the then current requirements of the CRA should ensure that all required language is in place. BHP anticipates another mass update of provider agreements to meet any new requirements under the CRA or other proposed changes for the Tenncare program may well be necessary in 2005. We will obtain TDCI's approval of the documents used to update the participation agreements before implementing any such update. In addition, the TRAS contract review committee now ensures that any amendments to TDCI approved form agreements are presented for TDCI review before execution.

D. Subcontracts

During the examination period, Advance PCS Health, LP (Advanced PCS) was subcontracted by BHP to provide pharmacy benefits. The Advance PCS contract was terminated effective July 1, 2003. At that time, the TennCare Bureau assumed responsibility for pharmacy services.

E. Title VI

Effective July 1996, Section 2-25. of the Contractor Risk Agreement required BHP to demonstrate compliance with Federal Title VI of the 1964 Civil Rights Act that prohibits discrimination based on race, color or national origin. Based on discussions with various BHP staff and a review of policies and related supporting documentation, BHP was in compliance with Section 2-25. of the Contractor Risk Agreement.

F. Internal Audit Function

The importance of an internal audit function is to provide an independent review and evaluation of the accuracy of financial recordkeeping, the reliability and integrity of information, the adequacy of internal controls, and compliance with applicable laws, policies, procedures, and regulations. An internal audit function is responsible for performing audits to ensure the economical and efficient use of resources by all

departments to accomplish the objectives and goals for the operations of the department. The internal audit department should report directly to the board of directors so the department can maintain its independence and objectivity.

BHP's internal audit function is responsible for the development, monitoring and testing of internal controls at BHP. This testing includes the quarterly claims payment accuracy report required by Section 2-9. of the Contractor Risk Agreement. BHP's Director of Internal Audit reports directly to the General Counsel at BHP. The General Counsel reports directly to a member of the board of directors.

G. Stabilization

Section 2-2.s. of Amendment 3 of BHP's Contractor Risk Agreement requires BHP to comply with the following:

> Agree to reimburse providers for the provision of covered services in accordance with reimbursement rates, reimbursement policies and procedures and medical management policies and procedures as they existed on April 16, 2002, unless otherwise directed or approved by TennCare, and to submit copies of all medical management policies and procedures in place as of April 16, 2002, to the State for the purpose of documenting medical management policies and procedures before final execution of this Amendment.

BHP's management has confirmed compliance with the stabilization requirements. During testing of financial, claims processing, and provider contracts, no deviations to the stabilization requirements were noted by TDCI and the Comptroller.

The examiners hereby acknowledge the courtesy and cooperation of the officers and employees of BHP.